State of California

California Department of Health Services
Medi-Cal Managed Care Division

Adolescent Collaborative
Interim Status Report
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Delmarva Foundation
Improving Healthcare in the Communities We Serve.

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Interim Report: Statewide Adolescent Collaborative

Introduction

Adolescence is a period of vigorous physical growth, intensified intellectual development, and complex emotional and social change. For this reason, the American Medical Association (AMA), the American Academy of Pediatrics (AAP), and the United States Maternal and Child Health Bureau (MCHB) uniformly recommend annual comprehensive visits for adolescents that include the assessment of physical, emotional, social, and behavioral risks that are unique to adolescents. Annual comprehensive adolescent well care visits are important in California because significant increases have been projected in the adolescent population, especially in families and communities with the lowest socioeconomic conditions. Adolescents from low income families often face significantly more challenges that interfere with their educational progress and social development and that place them at even higher risk for developing serious health conditions that are largely preventable.

In 2003, the California Department of Health Services (CDHS) Medi-Cal Managed Care Division (MMCD) implemented a multi-component Statewide Adolescent Health Collaborative Project to support the provision of comprehensive adolescent-friendly healthcare services that is provided to adolescents at the time of routine well care and episodic urgent care visits. Components of the project included surveying adolescent consumers about their health care visit, using adolescent health "champions" to promote change, establishing referral resources for providers to refer their adolescent patients, and sponsoring skills-based provider learning sessions that addressed content and process of the comprehensive adolescent healthcare visit.

The "Adolescent Report of Health Visit" consumer survey (adapted from a survey developed by the Division of Adolescent Medicine, University of California, San Francisco, 2001) was piloted by Blue Cross of California, Health Plan of San Joaquin and Partnership Health Plan for ten weeks in August to October 2004. Prior to beginning the provider learning sessions in September 2005, plans administered the survey as a baseline assessment of their participating providers in February through May 2005. The intent of the baseline measure was to ascertain from adolescents whether they thought their primary care provider had asked about various behavioral risks that could adversely affect their health, provided health education and counseling about those risks and inquired about their strengths and the positive assets in their lives. The survey re-assessment period is scheduled for implementation from February through June 2006 after completion of the provider skills-based learning sessions.

Skills-Based Provider Training Intervention

Skilled, knowledgeable providers who are interested in adolescent issues are generally more capable and comfortable with adolescents and are more likely to have a positive influence on adolescent decisions about

seeking care and compliance with treatment protocols. However; researchers theorize that lack of relevant knowledge and technical competence in adolescent health is a major reason physicians do not feel competent in working with adolescents. A review of current literature supports skills-based training on adolescent health for primary care providers as a way to improve comprehensive screening and counseling practices for adolescents (Lustig, Ozer, et al).

Addressing the needs of providers of health services for adolescents was a key part of the project and included several major components. First, each plan selected one or more adolescent health "champions for change" to serve as agents for clinical and provider practice change. The specific role of each champion was determined jointly by the plan and the champion. Selected champions could be individuals from the plan, provider network and/or local community and were expected to have a special interest in, knowledge about, or expertise and skills specific to adolescents and their healthcare. Another component was the provision of a list of local resources for obstetrics-gynecology; diet/nutrition and mental health/substance abuse that plans were expected to provide to each participating provider for referring their adolescent patients. These referral resources could include other network providers, community services and/or plan-specific resources. The third component was three regional one-day train-the-trainer sessions sponsored by CDHS and facilitated by adolescent medicine clinical consultants in which adolescent health champions learned techniques and practiced skills to enhance the provision of comprehensive adolescent health services. Learning sessions were held in Oakland, Orange County, and Los Angeles in which over 300 champions and providers attended.

Clinical specialists in adolescent medicine worked collaboratively with CDHS to develop training curriculum and learning modules and served as faculty presenters at the regional train-the-trainer and conference call learning sessions. Plans were expected to implement similar learning sessions with their participating network providers, but could determine how the sessions were implemented and the role of their selected adolescent health champion(s). Curriculum for the regional train-the-trainer learning sessions included the following:

- Adolescent Growth and Development: Implications for Clinical Care.
  Charles Irwin, MD, University of California, San Francisco.
- Confidentiality Issues and Teen-Friendly Services.
  Janet Shalwitz, MD, Adolescent Health Working Group, Inc.
- Screening Questions for Adolescent Clinical Preventive Services.
  Elizabeth Ozer, PhD, University of California, San Francisco.
- Strength-Based Approaches for Adolescents, and
- Improving Your Practice: Measurement for Improvement and Office System Redesign.
  Paula Duncan, MD, University of Vermont; National Institute for Children's Healthcare Quality.
  Emily Kallock, LCSW, University of Vermont Medical Center.

Interim Assessment Survey

In January 2006, Delmarva Foundation for Medical Care, Inc., the External Quality Review Organization (EQRO) contractor for the Medi-Cal Managed Care (MCMC) program sent a 20-question web-based interim assessment survey to all 20 contracted MCMC health plans. The purpose of the survey was to determine current project status and the methodologies used by plans to implement project strategies, such as provider learning sessions, roles of the champions for change, and availability of appropriate adolescent-specific referral resources for providers. (See survey tool in Appendix.) Nineteen of 20 plans returned the survey. This report describes the survey results from those 19 plans and summarizes their experiences in implementing the MMCD statewide adolescent health collaborative project. Data percentages will not result in 100% for any of the questions because most survey questions allowed for more than one response selection and for writing in individual responses under "other comments."

Data Findings

Learning Session Champions

The 19 survey respondents indicated that the provider learning sessions were most often conducted by plan staff members (84.2%), followed next by a physician or nurse champion from the provider network (68.4%). The majority (89.5%) of physicians conducting the provider learning sessions were pediatricians. Survey results showed that 79% of the adolescent health champions facilitated or participated in learning sessions in private practice settings (63.1%) or staff training sessions at the plan headquarters site (52.6%).

Learning Session Attendance

A variety of participants attended the learning sessions (Table 1), and the composition of attendees varied at each session. Learning session attendees ranged from physicians-only at some sites, to all or most clinic personnel at other sites (Figure 1). The majority (68.4%) of providers participating in the adolescent health project were from high-volume adolescent health practices. Community or public health clinics represented the next largest provider category at 57.9%, and small to mid-sized practices comprised 36.8%.

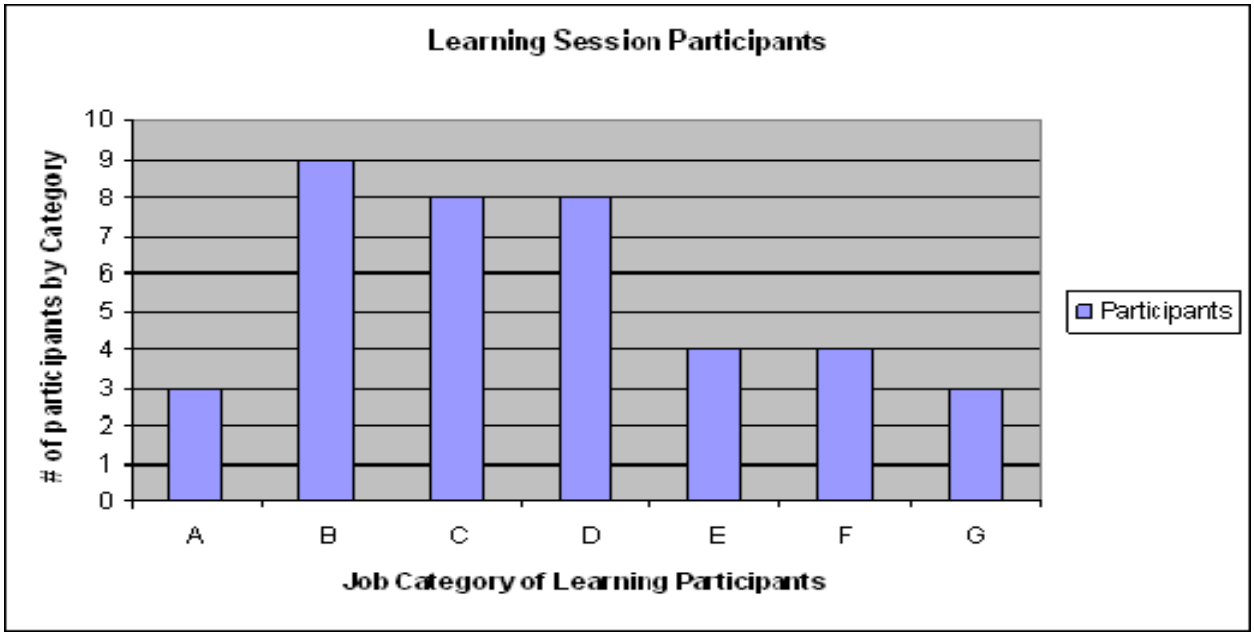
Table 1 – Learning Session Attendance by Job Category

Job Category	Learning Session Attendance
Non-physician clinicians	68.4%
Back office staff	57.9%
Physicians only	52.6%
Clinic managers	47.7%
Counselors; health educators	36.8%
Front office staff	31.6%

In February 2006, the number of learning sessions conducted by individual health plans ranged from 0 to 25. Five plans reported that one or more trainings had been conducted with only a portion of their participating provider practices or groups. Six (31.6%) health plans reported that although no formal learning sessions had been conducted by the time of the survey, educational materials had been disseminated throughout the network. Other plans reported that provider learning sessions were not scheduled to start until March or April 2006. Although the majority of plans had already conducted or were planning to conduct learning sessions, two plans reported they would not be conducting provider learning sessions. One plan, Blue Cross of California, reported they had sponsored 13 adolescent health learning sessions for their providers throughout the state earlier in 2005, so did not conduct formal training after the regional MMCD train-the-trainer sessions in September 2005. Similarly, prior to the start of this project, Kaiser North (GMC Sacramento) had implemented the same quality improvement model, training curriculum and educational presentations by the adolescent medicine faculty used for this project, so that formal learning sessions were not repeated with the Kaiser providers in 2005.

The number of participants attending each session varied greatly among health plans. Some plans held large didactic "continuing education" conferences, and some implemented individual on-site "roundtable" learning sessions. For example, LA Care reported that 70 participants attended a learning session held in September 2005, and that approximately 300 participants were expected to attend the session planned for April 2006. Eight (42.1%) health plans reported that their network learning sessions had been conducted on-site with individual provider practices or physician groups. The number of participants attending the individual on-site learning sessions ranged from 5 to 42.

Figure 1 – Learning Session Participants.



Categories of Learning Participants

A. All physicians who provide services to adolescents at participating sites.
B. At least one physician from each participating site.
C. Non-physician providers who deliver services to adolescents at participating sites.
D. Back office clinical staff from the majority of participating sites.
E. Front office clerical staff from the majority of participating sites.
F. Clinic and site managers from the majority of participating sites.
G. Sites who had all staff in attendance.

Barriers to Participation in Learning Sessions

The majority of health plans reported difficulty scheduling time with providers or site staff as a barrier to conducting the learning sessions (Table 2). Six plans reported insufficient resources available to implement changes as a barrier, although the types and degree of deficient resources were not identified. Three plans reported there were "no barriers" in conducting their adolescent health provider learning sessions.

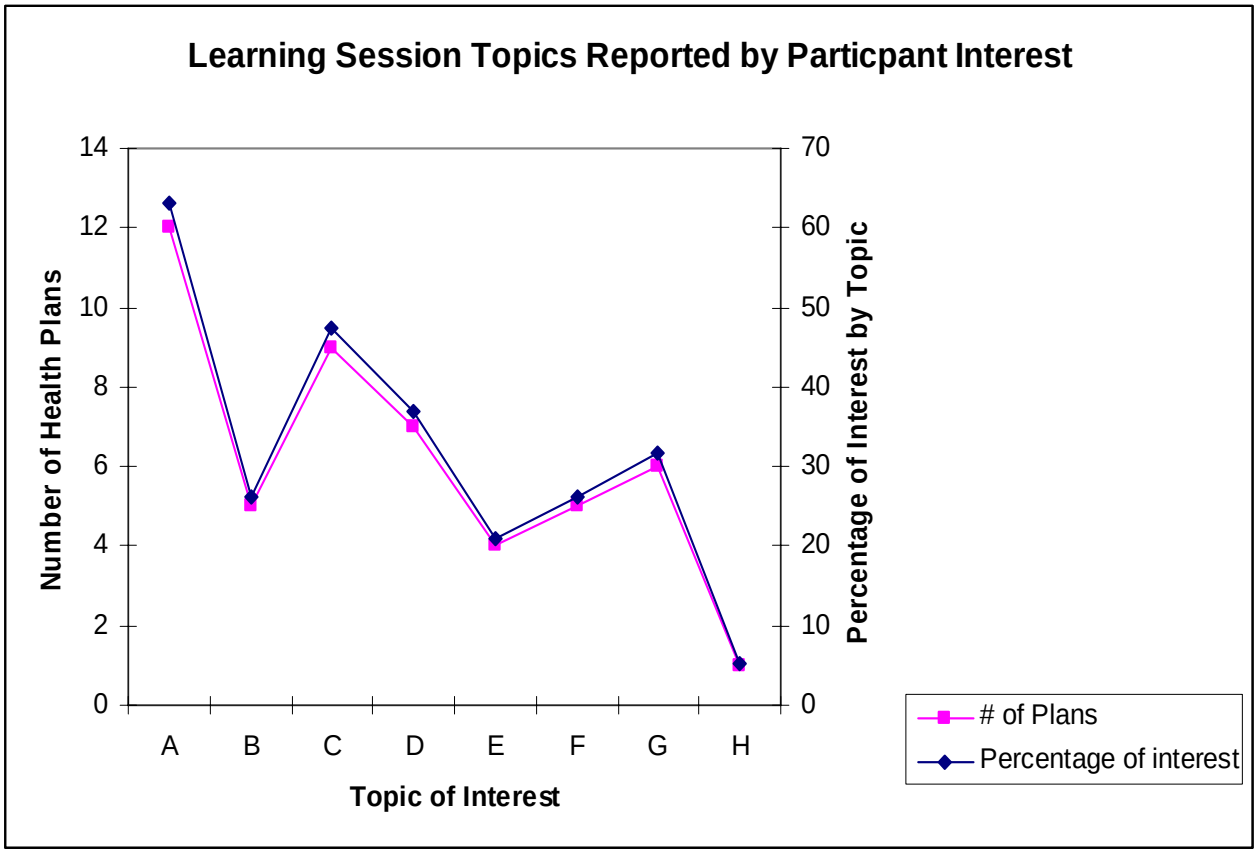
Table 2 — Barriers to Conducting Learning Sessions

Barriers	Heath plans	Percentage
Difficulty scheduling time with provider or staff	13	68.4%
Insufficient resources available to implement change	6	31.6%
Lack of provider interest	4	21%
Provider unwillingness to make changes	4	21%
Health plan felt unprepared to conduct learning sessions	4	21%
Lack of health plan administrative support	2	10.5%
Problems getting "champions" to conduct learning sessions	1	5.3%
No barriers reported	3	15.8%

Learning Session Topics of Interest

Plans reported the majority of learning session participants were *most* interested in "confidentiality and minor consent" (61.3%), techniques for interactive interviewing with adolescents (47.4%) and brief counseling for adolescents (36.8%) (Figure 2). Survey data showed that health plan respondents perceived confidentiality practices (73.7%) and adolescent-focused screening assessment and counseling (73.7%) as the most likely interventions to be implemented by participating providers and office staff (Table 3). The survey showed the topic that providers seemed *least* interested in was using Plan-Do-Study-Act (PDSA) cycles for making quality improvement changes in site-specific practice. Two plans reported that no new quality improvement strategies were likely to be implemented by their providers.

Figure 2 --- Learning Session Topics Reported by Participant Interest.



A. Confidentiality and minor consent.
B. Comprehensive screening and assessment for adolescents.
C. Techniques for interactive interviewing with adolescents.
D. Brief counseling on key health messages for adolescents.
E. Adolescent strengths-based assessment.
F. Office practice redesign for establishing teen-friendly sites.
G. Local referral resources.
H. Using PDSA cycles for site-specific practice quality improvement.

Table 3 --- Intervention Strategies Most Likely to be implemented by Provider Sites

Intervention	Health Plans	Percentage
Confidentiality Practices	14	73.7%
Adolescent-focused screening assessment and counseling	14	73.7%
Office redesign	5	26.3%
Strength-based assessments	4	21.0%
No strategies will be implemented	2	10.5%

Beneficial Adolescent Health Quality Improvement Strategies

From the outset, the statewide collaborative objectives were:

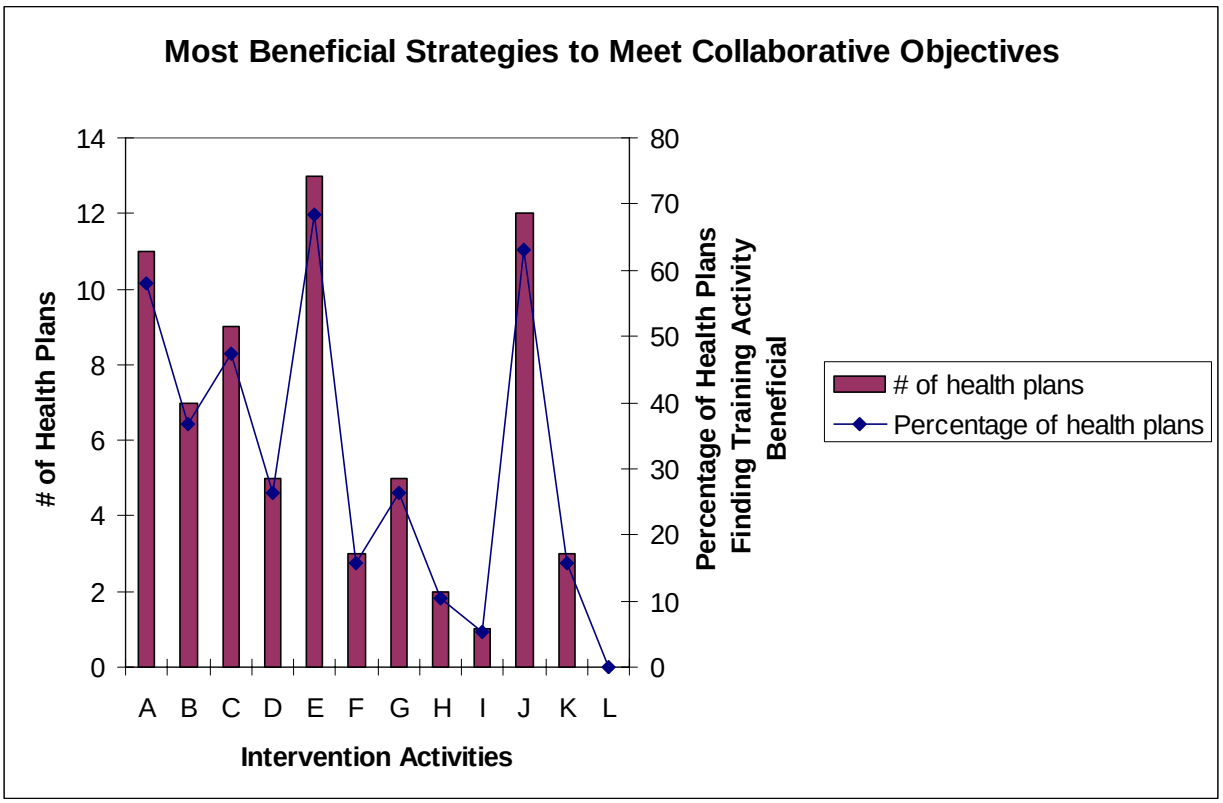
1. that adolescent MCMC beneficiaries receive an annual well-care visit per the AAP periodicity schedule and MCMC contract requirement; and
2. that a comprehensive assessment and health counseling and education are provided to adolescents at the time of routine well care and episodic visits.

A variety of interventions were implemented to support project strategies that specifically targeted the needs of providers in providing comprehensive assessment and counseling to adolescents (Figure 3). Plans were surveyed about the interventions that were the most and least beneficial to providers. Sixty-eight percent of the learning session participants found that "Practical Tools and Ideas for Providers" was the most beneficial to achieving collaborative objectives, and 65.1% found that the activities and materials that stated and demonstrated the "Provider Key Health Messages for Adolescents" was highly beneficial to their ability to provide comprehensive brief counseling. Learning session participants also reported the "availability of clinical adolescent experts to provide training and consultation in the learning sessions" and attending the "One Day Regional Train-the-Trainer Learning Sessions" as very beneficial strategies to their performance and success in the project.

Over half of the health plans reported the "postcard" brief survey tool for ongoing interim measurement of provider practice and behavior was the least beneficial activity attributable to meeting collaborative goals. The postcard survey, which included 14 questions from the larger "Adolescent Report of Visit" survey, was intended to be an interim measurement of provider practice related to new skills during the period following the skills-based learning sessions and before the beginning of the "Adolescent Report of Visit" survey re-measurement period. Over a period of one to three months, depending on when their provider learning sessions were completed, providers were to ask 5-10 adolescents to complete the brief postcard survey. Health plans were responsible for collecting and analyzing the postcard surveys and providing results and

follow-up technical assistance to providers. However; only two health plans (10.5%) actually implemented the interim "postcard" survey. One plan implemented the survey in one or more monthly cycles with all participating providers, and the other plan implemented the survey in one or more cycles with one or more selected providers. The major problem plans had with implementing the postcard survey was the very short period of time between completing the provider learning sessions in late fall/winter 2005 and beginning the "Adolescent Report of Visit" survey re-measurement in February through June 2006.

Figure 3 --- Most Beneficial Strategies.



A. Availability of clinical experts to provide training and consultation in learning sessions.
B. Provider and site-specific data from adolescent after-visit surveys.
C. One-day regional train-the-trainer learning session.
D. Train-the-trainer modules.
E. Practical tools and ideas for providers.
F. Practical tools and ideas for parents.
G. Interactive role play sessions using adolescent actors.
H. Approaches to strength-based assessment.
I. Postcard brief survey methodology and tool for ongoing interim measurement of provider practice and behavior.
J. Provider key health messages for adolescents.
K. One-hour adolescent health conference call learning session series.
L. Practical examples of PDSA cycle to improve practice and for office redesign.

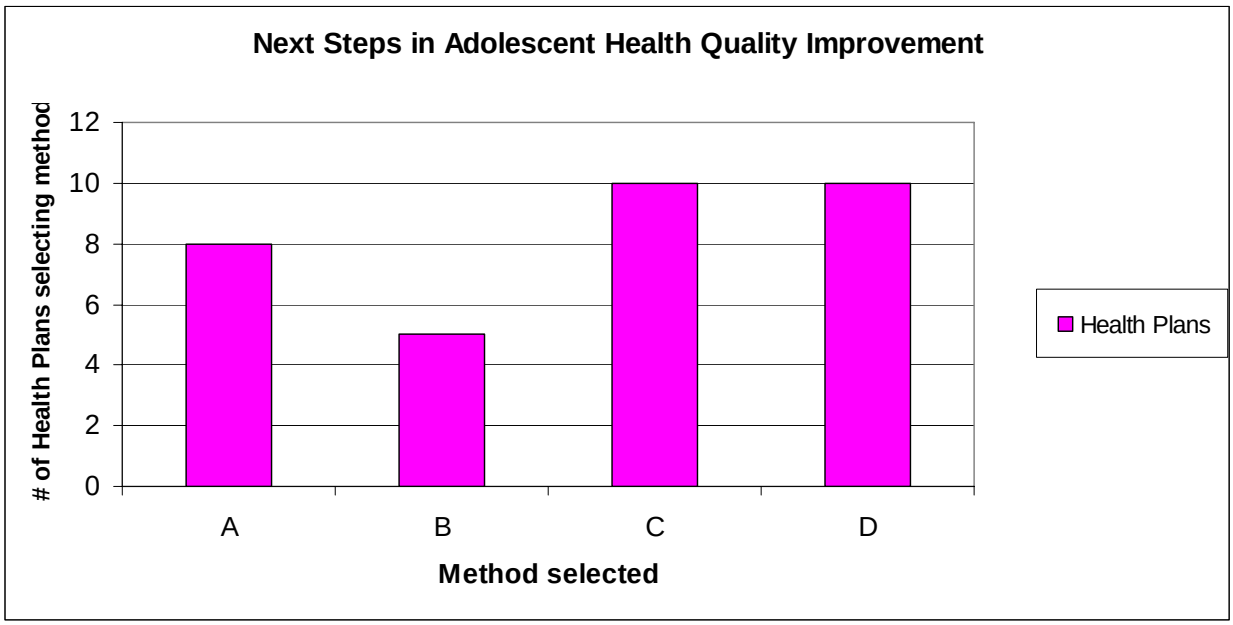
Next Steps for Health Plans

Ten plans (52.6%) reported two important next steps for future activities in the adolescent health quality improvement project (Figure 4).

1. Develop a plan to assess whether current participating providers have sustained strategies for working with adolescent members.
2. Develop a plan to assess the impact of quality improvement strategies on Health Employer Data Information Set (HEDIS®) rates.

Approximately 42% of health plans reported that development of a long term plan to spread the quality improvement strategies initiated in this project across the provider network is a necessary step to support sustainability of the improvements made. Since many "high-volume" providers initially participated in this project, plans reported that a formal "spread" strategy would be useful in raising the quality of care across the network to mid-sized and small provider practice sites. Steps for implementation of spread strategies over the next project year will be jointly determined by the health plans, CDHS and Delmarva.

Figure 4 --- Next Steps in Adolescent Health Quality Improvement.



A. Develop a formal long-term plan to spread quality improvement strategies across provider network.
B. Implement formal plan to "spread" adolescent health trainings to other network providers.
C. Develop a plan to assess whether current participating providers have sustained strategies.
D. Develop a plan to assess impact of quality improvement strategies on HEDIS rates.

Conclusion

The strategies implemented in this project reflect the best practice concepts found in the literature, as well as the areas for needed quality improvement identified by health plans. One basic principle found in the literature was that adolescents and their parents see health care providers as credible sources of health information and want clinicians to address health risk behaviors and prevention topics. According to the American Association of Health Plans, young people expect health professionals to advise them about sensitive health-related topics. Providing skills-based training about adolescent health issues and adolescent-friendly interviewing and counseling techniques is an appropriate best practice strategy for health care providers (Lustig, Ozer, et al).

Two other best practice principles identified in the literature included the importance of including adolescents in quality improvement activities (Partners in Transition, 2000) and that "adolescent-friendly" sites are integral to the adolescent health visit. In the skills-based provider learning sessions, young actors were utilized to portray adolescent clients which allowed champion trainers and providers to observe and "practice" interactive health risk interviewing and health messaging techniques within a safe environment. Constructive feedback from the young actors, adolescent health faculty and other participants provided opportunities for self evaluation and practice in interactive interviewing and counseling skills. Additionally, along with provider skills, faculty consultants emphasized the following attributes as essential to an adolescent-friendly site:

1. Site staff and environment supports confidentiality and privacy, including time alone with provider;
2. Adolescent healthcare services focus on comprehensive health risk issues specific to adolescents;
3. Clinical site staff are skilled in interactive interviewing and brief counseling techniques;
4. Comprehensive assessment includes the adolescent's individual strengths and positive assets;
5. Adequate time is allowed for adolescent well-care appointment visits;
6. Referral resources specific to adolescent care are readily available to providers; and
7. Adolescents are included in planning, implementing and/or evaluating healthcare services.

Growing demands on the California healthcare system are expected to increase in part due to the growing adolescent population, especially among groups that often have poorer health outcomes and less access to health care. Implementation of the MMCD Adolescent Health Collaborative Project has provided the MMCD, health plans and practicing clinicians with the unique opportunity to focus on systemic and provider practice issues related to providing quality health care to adolescents. It is evident that providers recognize the importance for staff in primary care sites serving adolescents to support the dignity and confidentiality of adolescents, demonstrate respect for adolescents as individuals, and provide the quality comprehensive healthcare services that will result in early detection of actual and potential health risks and early intervention and treatment of health problems.

References

Lustig J, Ozer E, Adams S, Wibblesman C, Fuster C, Boner R, Irwin C (2001). *Improving the delivery of adolescent clinical preventive services through skills-based training.* Pediatrics 107(5): 1100-1107.

McIntyre, P. (2002, October). *Adolescent friendly health services: An agenda for change.* Geneva, Switzerland: World Health Organization.

Partners in Transition: Adolescents and managed care (2000, April), *Children Now* (Strategy 8).

Senderowitz, J. (1997). *Making reproductive health services youth friendly* (Ch. 8). Durham, NC: Family Health International.

Appendix: Adolescent Collaborative Interim Survey

Please note: The survey sent out to health plans by email contained errors in items 1, 2, and 19. Those survey items were *not included* for analysis in this report. This is the correct survey.

Health Plan Name:_____

Position of Person Completing:_____

1. **Our selected adolescent health champion(s) included the following: (Select all that apply.)**
   - **A. Pediatrician**
   - **B. Adolescent medicine physician**
   - **C. General/family practice physician**
   - **D. Internal medicine physician**
   - **E. Nurse practitioner/registered nurse**
   - **F. Health educator**
   - **G. Social worker**
   - **H. Behavioral/mental health counselor or specialist**
   - **I. Other** _____

2. **The adolescent health champion(s) are from the following settings: (Select all that apply.)**
   - **A. Private practice**
   - **B. School-based clinic**
   - **C. Community clinic**
   - **D. County public health agency**
   - **E. Hospital**
   - **F. University/college/learning institution**
   - **G. Mental health agency**
   - **H. Our MCO**
   - **I. Another MCO**
   - **J. Retired**
   - **K. Other** _____

3. **The adolescent health champion(s) supported our quality improvement project in the following ways: (Select all that apply.)**
   - **A. Facilitated/participated in training sessions for participating network providers**
   - **B. Served as expert consultant to MCO staff on adolescent health issues**
   - **C. Served as expert consultant to net work providers**
   - **D. Served as the champion for quality improvement changes on his or her practice site**
   - **E. Attended the DHS/MMCD 1-day train-the-trainer learning session**
   - **F. Advocated for coordination and provision of quality adolescent health services to local healthcare agencies, school groups, community groups, etc.**
   - **G. Worked directly with adolescents and/or their parents**
   - **H. Facilitated/participated in focus groups (provider, adolescent, parent, etc.)**
   - **I. Wrote articles for provider or member newsletter or other publication(s)**
   - **J. Worked to develop practice guidelines, referral systems, documentation tools, etc.**
   - **K. Other_____**

4. **Which of the following best describes the *majority* of your participating providers in the adolescent health quality improvement collaborative? (Select up to 3 items.)**
   - **A. High-volume providers of adolescent services**
   - **B. Small to medium-sized private practices**
   - **C. School-based and/or school-associated health centers**
   - **D. Community or public health clinics**
   - **E. University/learning institution clinics**
   - **F. Staff model provider sites**
   - **G. Other _____**

5. **Our participating providers were *most* interested/enthusiastic about the following: (Select top 3 items.)**
   - **A. Confidentiality and minor consent**
   - **B. Comprehensive screening and assessment for adolescents**
   - **C. Techniques for interactive interviewing with adolescents**
   - **D. Brief counseling on key health messages for adolescents**
   - **E. Adolescent strengths-based assets assessment**
   - **F. Office practice redesign for establishing teen-friendly sites**
   - **G. Local referral resources**
   - **H. Using PDSA cycles for site-specific practice quality improvement**
   - **I. Other _____**

6. **Our participating providers were *least* interested/enthusiastic about the following: (Select top 3 items.)**
   - **A. Confidentiality and minor consent**
   - **B. Comprehensive screening and assessment for adolescents**
   - **C. Techniques for interactive interviewing with adolescents**
   - **D. Brief counseling on key health messages for adolescents**
   - **E. Adolescent strengths-based assets assessment**
   - **F. Office practice redesign for establishing teen-friendly sites**
   - **G. Local referral resources**
   - **H. Using PDSA cycles for site-specific practice quality improvement**
   - **I. Other _____**

7. **The trainers for our participating network providers included the following:**
   - **A. Physician or nurse champion from our provider network**
   - **B. Our MCO medical director or other MCO physician(s)**
   - **C. Our MCO staff (e.g., quality improvement, health education, provider relations)**
   - **D. Medical director, physician, and/or staff from *another* MCO health plan**
   - **E. Adolescent health experts or clinical specialists from local community agencies**
   - **F. Contracted adolescent health experts or clinical specialists from outside of local area**
   - **G. Other _____**

8. **Which of the following best describes your adolescent health provider learning sessions? (Select all that apply.)**
   - **A. One formal didactic CME training (e.g., dinner session, formal meeting)**
   - **B. Two or more formal didactic CME trainings (e.g., dinner sessions, formal meetings)**
   - **C. One individual onsite session with each participating provider/group**
   - **D. Two or more individual onsite sessions with each participating provider/group**
   - **E. One or more training sessions with some of the participating providers/groups**
   - **F. Computerized/electronic training program**
   - **G. Didactic and/or onsite sessions done collaboratively with other MCO(s)**
   - **H. No training sessions were held, but educational materials were distributed**

9. **Number of different sites trained? _____** (Fill in the number)

10. **Number of attendees at the formal didactic sessions? _____** (Fill in the number)

11. **Which of the following best describes the individuals that attended your provider learning sessions? (Select all that apply to the majority of learning sessions provided.)**
    - **A. Physicians only**
    - **B. Non-physician providers (e.g., nurse practitioners, physician assistant)**
    - **C. Back office staff (e.g., clinical)**
    - **D. Front office staff (e.g., clerical)**
    - **E. Counselors, health educators, etc.**
    - **F. Clinic managers**
    - **G. Other _____**

12. **Which of the following best describes the participation at your provider learning sessions? (Select all that apply to the learning sessions provided.)**
    - **A. All physicians who provide services to adolescents on participating sites attended.**
    - **B. At least one physician from each participating site attended.**
    - **C. Non-physician providers (nurse practitioners, physician assistant) who provide services to adolescents on participating sites attended.**
    - **D. Back office staff (clinical) from the majority of participating sites attended.**
    - **E. Front office staff (clerical) from the majority of participating sites attended.**
    - **F. Clinic/site managers from the majority of participating sites attended.**
    - **G. The majority of sites had *all* staff in attendance (e.g., provider, non-physician providers, front and back office staff, managers).**
    - **H. Other _____**

13. **We experienced the following barriers in performing the adolescent health provider training: (Select all that you experienced.)**
    - **A. Difficulty scheduling time with provider/site staff**
    - **B. Insufficient provider/staff resources to implement strategies**
    - **C. Lack of provider/site staff interest**
    - **D. Insufficient MCO resources to conduct trainings**
    - **E. Attitude/unwillingness of provider/staff regarding making changes in office practice**
    - **F. Lack of MCO support at administrative/management level**
    - **G. Problems with accessing champions to assist with trainings**
    - **H. MCO training staff felt unprepared to conduct trainings**
    - **I. No barriers experienced**
    - **J. Other _____**

14. **Of all the strategies taught, we anticipate that the practices/practitioners will most likely implement the following strategies:**

A. Office redesign practices to promote an adolescent-friendly environment
B. Confidentiality practices
C. Adolescent-focused screening assessment and counseling
D. Strength-based assessments
E. Other _____
F. None of the above

15. After completing your provider training, the interim "postcard" survey was:
A. Completed in one or more cycles with all participating providers
B. Completed in one or more cycles with one or more selected providers
C. Not completed at all with any providers

16. After the adolescent after-visit survey re-measurement is completed, the next steps for my MCO over the next year will include:
A. Developing a formal long-term plan to spread these quality improvement strategies across the provider network
B. Implementing our formal plan to "spread" the adolescent health trainings to other network providers
C. Develop a plan to assess whether current participating providers have sustained strategies for working with adolescents members
D. Developing a plan to assess impact of quality improvement strategies on HEDIS rates
E. Other _____

17. Which of the following was *most* beneficial to your activities for the adolescent health quality improvement collaborative? (Select top 3 items.)
A. Availability of clinical experts in adolescent health services to provide training and consultation in learning sessions
B. Provider and/or site-specific data from adolescent after-visit surveys
C. One-day regional train-the-trainer learning session
D. Train-the-trainer modules
E. Practical tools/ideas (e.g., posters, handouts) for providers
F. Practical tools/ideas (e.g., letters) for parents
G. Interactive role play sessions using "adolescent" actors
H. Approaches to strengths-based asset assessment
I. Postcard brief survey methodology and tool for ongoing interim measurement of provider practice/behavior
J. Provider key health messages for adolescents
K. One-hour adolescent health conference call learning session series
L. Practical examples of PDSA cycle to improve practice and for office redesign

M. Other _____

18. Which of the following was *least* beneficial to your activities for the adolescent health quality improvement collaborative? (Select top 3 items.)
    A. Availability of clinical experts in adolescent health services to provide training and consultation in learning sessions
    B. Provider and/or site-specific data from adolescent after-visit surveys
    C. One-day regional train-the-trainer learning session
    D. Train-the-trainer modules
    E. Practical tools/ideas (e.g., posters, handouts) for providers
    F. Practical tools/ideas (e.g., letters) for parents
    G. Interactive role play sessions using "adolescent" actors
    H. Approaches to strengths-based asset assessment
    I. Postcard brief survey methodology and tool for ongoing interim measurement of provider practice/behavior
    J. Provider key health messages for adolescents
    K. One-hour adolescent health conference call learning session series
    L. Practical examples of PDSA cycle to improve practice and for office redesign
    M. Other _____

19. My plan provided the following referral resources specific to adolescent services for participating providers. (Select all that apply.)
    A. One or more local community agencies/providers for mental health/substance abuse referrals.
    B. One or more local community agencies/providers for obstetric/gynecology referrals.
    C. One or more local community agencies/providers for nutrition/diet referrals.
    D. In-plan or plan contracted agency/provider for mental health/substance abuse referrals.
    E. In-plan or plan contracted agency/provider for obstetric/gynecology referrals.
    F. In-plan or plan contracted agency/provider for nutrition/diet referrals.
    G. Other methods for providing referral resources include _____ (please describe).